NYOH New York Oncology Hematology
www.newyorkoncology.com

Patient History & Physical

Date_____

Name (First & Last)_____ **Acct. #** _____

Date of Birth: _____ **Referring Physician:** _____
Primary Care Physician: _____
OB/GYN Physician: _____

Gender Identity:
☐Male ☐ Female ☐ Additional gender category/other **please specify**_____
☐Choose not to disclose

Home Address: _____
Street City State Zip

Phone Number: Home (____) _____ Cell (____) _____ Work (____) _____

PLEASE LIST ANY OTHER PHYSICIANS TO WHOM YOU WOULD LIKE COPIES OF INFORMATION SENT:

	Name	Problem Cared For
1.		
2.		
3.		

Pharmacy: Name: _____Phone: (____) _____
Address: _____

Medications: Please list **ALL** current prescriptions and over-the-counter medications. Include herbals, supplements, and vitamins.

Medication	Dosage (ex. mg, ml,)	How often	When prescribed

LATEX ALLERGY ☐ Yes ☐ No **Are you on Oxygen?** ☐ Yes ☐ No

Allergies: Are you allergic to any medications? ☐ Yes ☐ No If yes, please list the medication **and** type of reaction:

1. _____ 3. _____
2. _____ 4. _____

PATIENT INSTRUCTIONS: Please make sure you complete all 5 pages • Do NOT detach any pages from the stub

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Hospitalizations/Surgeries: Please list all hospitalizations and surgeries:

Date	Reason for Hospitalizations or Type of Surgery	Where	Doctor

Procedures: Please list procedure details and year occurred (e.g. pacemaker, dental extractions):

Date	Procedure	Where	Doctor

Previous Treatment for Cancer (if applicable)	Mo./Yr.	Radiation Site / Chemo Type	Where Treated
Radiation Therapy			
Chemotherapy/Immunotherapy/Targeted Therapy			
Hormone Therapy			

Blood Transfusions: Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, did you have a reaction? ☐ Yes ☐ No
Date of Last Transfusion:_____

Personal Medical History: Please check if you have had or currently have any of the following. Include date of diagnosis

		Date
☐	Anemia	
☐	Arthritis/Chronic Pain	
☐	Asthma	
☐	Blood Disorder/Blood Clots	
☐	Bladder Problems	
☐	Cancer type: _____	
☐	Colitis/Crohn's Disease	
☐	Connective Tissue Disease (Lupus)	
☐	COPD/Emphysema	
☐	Congestive Heart Failure	
☐	Depression/Anxiety	
☐	Diabetes	
☐	Heart Condition (Afib, Heart Attack)	
☐	High Blood Pressure	
☐	High Cholesterol	

		Date
☐	Jaundice/Hepatitis Type _____	
☐	Kidney Disease	
☐	Liver/Gallbladder Disease	
☐	Measles/Mumps/Rubella/Chicken Pox	
☐	Mental Illness	
☐	Migraine Headaches/Frequent Headaches	
☐	Seizure Disorder	
☐	Sexually Transmitted Diseases (Herpes, AIDS)	
☐	Skin Disease (eczema, psoriasis, hives)	
☐	Stroke	
☐	Thyroid Problem	
Other medical problems not listed (add below)		

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Name (First & Last)_____ **Acct. #** _____

Social History:

Race: _____ Ethnicity: _____ Preferred Language: _____

Marital Status:
☐ Married ☐ Single
☐ Divorced ☐ Separated
☐ Widowed
☐ Domestic Partner

Living Arrangements:
☐ Alone ☐ With Spouse
☐ With Significant Other
☐ Supervised Living
☐ Other_____

Do you have children? ☐ Yes ☐ No
If yes, how many children: _____

➢ **Advance Care Planning (ACP) is an ongoing process of learning about the choices we each have for our future medical care.**
Please check if you have any of the following as part of your ACP:

☐ Organ Donor Card ☐ Health Care Proxy ☐ Power of Attorney ☐ Living Will

****If you have signed any of these legal documents, please bring copies to your next appointment**

Would you like more information on any of these? ☐ Yes ☐ No

➢ Do you have Do Not Resuscitate Forms? ☐ Yes ☐ No

➢ Is there someone who you would like to list as your primary contact regarding your healthcare? ☐ Yes ☐ No

If yes, Name: _____ Relationship: _____ Phone: _____

➢ **Occupation** (previous if retired): _____Employer: _____
☐ Retired

➢ **Do you now or did you ever:**

Smoke cigarettes/cigars/pipes/vaping/chewing tobacco ☐Yes ☐No Pack/Day ____ #YRS _____ When Quit _____

Consume Alcohol? ☐Yes ☐No Drinks/day _____ Drinks/week _____ When Quit _____

Use Illegal Drugs? ☐Yes ☐No Which ones? _____ When Quit _____

➢ **List month/year you last had:**

_____ Flu Vaccine _____ Hepatitis Vaccine _____ Pneumonia Shot _____ Tetanus Shot _____TB Test (PPD)
_____ Eye Exam _____Dental Visit _____Stool Blood Test _____ Rectal Exam ____ Colonoscopy/Sigmoid Exam

MALE ONLY:
Last PSA screening: _____ Last prostate exam: _____

FEMALE ONLY:
Age at First Menstrual Period _____ If still menstruating, date of last period _____
Age at Menopause _____ Have you ever taken birth control pills? ☐Yes ☐No How Long _____ Yrs
Do you now use birth control? ☐Yes ☐No Type _____
Have you ever taken fertility drug treatments? ☐Yes ☐No
Have you ever taken hormone replacements? ☐Yes ☐No How Long _____Yrs
Are you currently taking hormone replacements? ☐Yes ☐No Type _____
Number of Pregnancies _____ Number of Live Births _____ Age at first childbirth_____
Did you breast feed? ☐Yes ☐No How Long _____

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FEMALE ONLY CONTINUED:

Year of Last: _____ Pap Test ☐Normal ☐Abnormal
_____ Breast Exam ☐Normal ☐Abnormal
_____Mammogram ☐Normal ☐Abnormal

Do you perform monthly self-breast exam? ☐Yes ☐No

FAMILY HISTORY

Relative	Alive or Deceased	EVER HAD CANCER?	Age at Cancer diagnosis	Type of Cancer (breast, colon, lung, etc.)	Other Medical Problem (heart disease, diabetes, etc.)
Biological Mother	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
Biological Father	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
Maternal Grandmother	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
Maternal Grandfather	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
Paternal Grandmother	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
Paternal Grandfather	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
BIOLOGICAL SIBLINGS					
1.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
2.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
3.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
4.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
Additional:					
BIOLOGICAL CHILDREN					
1.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
2.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
3.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
Additional:					
OTHER RELATIVES (ex. cousin, aunts/uncles)					
1.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
2.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			
3.	☐A ☐D	☐Yes ☐No ☐UNKNOWN			

Name (First & Last)_____ Acct. # _____

ARE YOU ***CURRENTLY*** EXPERIENCING ANY OF THE FOLLOWING? CHECK ***ALL*** THAT APPLY.

CONSTITUTIONAL

- ☐ No problems or concerns
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Fevers / Chills
- ☐ Night sweats
- ☐ Excessive itching
- ☐ Food supplements
- ☐ On a diet now *Type*_____ _____ Number of meals daily

EYES

- ☐ No problems or concerns
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Vision loss
- ☐ Other:_____

EAR, NOSE, MOUTH, THROAT

- ☐ No problems or concerns
- ☐ Hearing loss
- ☐ Dental problem
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Other:_____

CARDIOLOGY

- ☐ No problems or concerns
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Rapid / Irregular heart beat
- ☐ Chest pain / Tightness
- ☐ Pacemaker / Defibrillator
- ☐ Ankle swelling
- ☐ Leg cramps at night
- ☐ Other:_____

RESPIRATORY

- ☐ No problems or concerns
- ☐ Asthma / Bronchitis / Emphysema
- ☐ Shortness of breath
- ☐ Cough that produces blood
- ☐ Other:_____

GASTROINTESTINAL

- ☐ No problems or concerns
- ☐ Loss of appetite
- ☐ Heartburn or indigestion
- ☐ Stomach pain or discomfort
- ☐ Frequent nausea / Vomiting
- ☐ Recurrent diarrhea / Constipation
- ☐ Bloody stools
- ☐ Black, tarry stools
- ☐ Difficulty swallowing
- ☐ Other:_____

(Please do not forget to complete right side column)

▼ Office Use Only ▼

_____
M.D. Signature Date

GENITOURINARY

- ☐ No problems or concerns
- ☐ Difficulty urinating
- ☐ Frequent / Painful urination
- ☐ Recurrent bladder infection
- ☐ Vaginal itching / Discharge
- ☐ Sexual problems
- ☐ Blood in urine
- ☐ Other:_____

MUSCULOSKELETAL

- ☐ No problems or concerns
- ☐ Difficulty walking
- ☐ Joint aches or stiffness
- ☐ Painful legs / Feet
- ☐ Back ache / Pain
- ☐ Other:_____

NEUROLOGIC

- ☐ No problems or concerns
- ☐ Difficulty concentrating
- ☐ Headache
- ☐ Dizziness / Fainting / Blackouts
- ☐ Numbness hands / Feet
- ☐ Seizures / Convulsions
- ☐ Memory changes
- ☐ Other:_____

PSYCHOSOCIAL

- ☐ No problems or concerns
- ☐ Nightmares
- ☐ Anxious / Nervous
- ☐ Trouble sleeping
- ☐ Lonely / Depressed
- ☐ Work / Family problems
- ☐ Tire easily
- ☐ Other:_____

ENDOCRINE

- ☐ No problems or concerns
- ☐ Thyroid problems
- ☐ Blood sugar problems
- ☐ Excessive sweating
- ☐ Other:_____

SKIN / BREAST

- ☐ No problems or concerns
- ☐ Sores / Rashes
- ☐ Moles
- ☐ Nipple discharge
- ☐ Change in breast size
- ☐ Lump / Pain
- ☐ Other:_____

HEMATOLOGIC / LYMPHATIC

- ☐ No problems or concerns
- ☐ Easy bleeding / Bruising
- ☐ Anemia or blood problem
- ☐ Frequent infections
- ☐ Swelling of glands
- ☐ Swelling of hands / Feet
- ☐ Other:_____

ALLERGIC / IMMUNOLOGIC

- ☐ No problems or concerns
- ☐ Facial swelling
- ☐ Tightening of throat
- ☐ Hives
- ☐ Other:_____